

Why Every Woman Over 40 Isn't in a Breast Cancer Detection Program

TO THE EDITOR: Why isn't every woman over 40 in a breast cancer detection program? It is interesting to read the conclusion of Dr Robertson that the reason is poor compliance by physicians with screening recommendations.¹ The recommendations of the American Cancer Society and the American College of Radiology have the prestige, but it takes more than that. There are no uniform standards of care, preventive or otherwise, established by organized medicine or the government. Certainly, there are no mandatory requirements—which might not be a bad idea. The medical background, experiences, and practices of a half million physicians are divergent.

The elderly, the poor, the uneducated, and ethnic minorities are segments of the population not well penetrated by our health crusades. These groups are reluctant to seek medical advice when asymptomatic and often even with symptoms.

The middle class is more responsive to health education. Even here, however, asymptomatic persons have limited time, interest, and resources allocated to health. They are under a constant bombardment by medicine, family, and friends regarding diet, calories, salt, fat, sugar, cholesterol, calcium, vitamins, blood tests, cardiograms, pap smears, exercise, stress management, and so forth. The middle class shows a certain exhaustion from an overdose of health information.

Personality is a major key. Some people love to be medicated, pampered. They love interviews, examinations, tests, operations, whatever is fashionable. Others are uninterested or fearful of discovering an illness. They deny symptoms and reject an aggressive medical approach. They seek out health practitioners who are less forceful and demanding.

We physicians are also under economic pressures. It is difficult to coax an asymptomatic patient to have routine physicals or preventive tests at a time when insurance companies will not cover them or they carry high deductibles. My perspective is one of the general physician-surgeon: a complex of social, psychological, and economic problems. Why isn't every woman over 40 in a breast cancer detection program? I think that all women are, to the extent reality permits. We cannot force a mammogram as we can force a vaccination for a child or a pap smear for a woman on birth control pills. In spite of these difficulties, the use of mammograms and discovery of early cancers are increasing but not faster than the sophistication and prosperity of the general population.

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REFERENCE

1. Robertson CL: Why isn't every woman over 40 in a breast cancer detection program? *West J Med* 1988; 149:111-112

Economies of Scale

TO THE EDITOR: In your editorial, "On Specialized Centers for Patient Care" in the July 1988 issue,¹ you discussed the economies of scale thought to exist in specialized care centers, and you stated that economies of scale result in better quality of specialized care given at the specialized care center. Improved cost of such care, however, was not confirmed because supporting data were not available.

It seems sensible, a priori, that greater experience derived

from providing frequent replication of highly complex care would produce a better technical quality in a shorter elapsed time. But lower costs for this care will not result so long as a piecework payment (fee for service) system exists. If cost economies of scale are to be realized, large-volume, complex technical care will have to be provided by salaried technicians, working at hourly payment rates, with incentives to increase productivity.

Because physician payment is not yet made at hourly rates, it appears ridiculous to expect economies of scale to apply to physician services.

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REFERENCE

1. Watts MSM: On specialized centers for patient care (Editorial). *West J Med* 1988; 149:80

Fluoride in Mineral Water

TO THE EDITOR: Commenting on an article by Russell and colleagues in the November 1987 issue,¹ Dr Robert Isman, Chief, Office of Dental Health, Department of Health Services, State of California, stated that "Such heavy exposure is associated with a level of at least 10 ppm in the drinking water supply." These fluoride levels do not exist in the US, and there have been no reported cases of crippling fluorosis in the United States.²

Dr Isman may be correct in asserting that there have been no reported cases of crippling fluorosis in the United States, but he is not correct in assuming that all drinking water supplies are under 10 ppm fluoride level.

In a lawsuit in San Francisco, *Burton et al v Source Perrier et al* (SF Superior Court Cir No. 810212), the Food and Drug Administration, in response to a Freedom of Information Act request about Calistoga bottled mineral water, provided numerous analyses of expensive bottled drinking water with fluoride levels in excess of 10 ppm. Calistoga Sparkling Mineral Water and Orange Flavored Mineral Water frequently exceeded the fluoride levels Dr Isman asserts do not exist in the US.

Further information may be obtained from Alioto & Alioto, 650 California Street, San Francisco, CA 94108.

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REFERENCES

1. Russell HH, Jackson RJ, Spath DP, et al: Chemical contamination of California drinking water. *West J Med* 1987; 147:615-622
2. Isman R: Fluoride contamination (Correspondence). *West J Med* 1988; 148:708-709

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Dr Isman Responds

TO THE EDITOR: Dr LaDou is correct in his assertion that Calistoga bottled mineral water at one time contained fluoride levels in excess of 10 ppm. Since January 1, 1988, however, California law has required mineral water to be treated to reduce the concentration of any naturally occurring substance that exceeds the bottled water safety standards established by the Department of Health Services. For fluoride, these standards limit the concentration to between 1.4 and 2.4 ppm, depending on the annual average of maximum daily air temperatures. Mineral water producers who bottle

5,000 gallons or less per week have until January 1, 1989, to comply with these standards.

The point of my statement was that fluoride levels of 10 ppm in the public drinking water supply do not exist in the United States. Calistoga mineral water and several other bottled mineral waters come from thermal aquifers that are not sources of public drinking water. The highest fluoride concentration of any of the several sources of public drinking water in the city of Calistoga is 0.23 ppm.

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On the Meaning of Words

TO THE EDITOR: The words research, experiment, and investigate are frequently used interchangeably by members of the scientific community; standard dictionaries consider these words synonymous or analogous. No pertinent references concerning the definition or use of these words could be found in either the medical or legal libraries at the University of New Mexico.

That the concern over the interchangeable use of the words research, experiment, and investigate can be at times more than a mere exercise in semantics was brought to the attention of the authors when, during a recent trial, the plaintiff's attorney informed the jury, with emphasis, that the defendant had performed research on the plaintiff. This, despite the fact the plaintiff's attorney was well aware that the defendant had conscientiously engaged in laboratory research by doing an adequate series of experiments on dogs to investigate (determine) the feasibility of a new operation. The defendant had also presented his data to the Human Research Review Committee of the University of New Mexico School of Medicine.

We suggest that the words research, experiment, and investigate be reserved for the chemistry, biology, or animal laboratory and recommend that when the use of a new drug, device, procedure, or operation is applied to humans, the term clinical trial be used. In time, the distinction between laboratory research and clinical trial will, we hope, become more universally accepted. This would ameliorate confusion and the implication of assault on the human body. It might further deny some future plaintiff's attorney the opportunity of inaccurately implying that the defendant has treated a patient improperly.

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The Yin and Yang of Medical Practice

TO THE EDITOR: I congratulate Drs Botticelli and Gilbert for attempting to clarify, in the July 1988 issue, the two factions of modern medical practice by presenting these aspects within the context of the yin yang wisdom.¹

If we are truly sincere in our effort to bring a balance between the personal aspect of medicine—the patient/doctor/illness—and the impersonal aspect—technology, business, and politics of medicine—within the context of yin yang, we must start with the correct premise. For this we

need to return to the I Ching, which states the positions of yin (earth) and yang (heaven) and what they further represent.

“Yang—the Creative is heaven, metal, cold, ice, the father . . .

“Yin—the Receptive is the earth, the mother. It is cloth, a kettle (to contain the creative process), it is level, it is a cow with a calf, a large wagon, form and the multitude. . . .”² (The opposite of the oneness of Yang.)

Technology is penetrating. Our patient is receptive.

Relationship requires receptivity from physician and patient and receptivity is the yin—the feminine principle. Technology and the other impersonal aspects of medicine, business, and politics belong to yang, the masculine principle. I agree so much with what you say, that the necessity now is a balance in our valuing equally each aspect, and yes, there should be no warring when we try to achieve balance.

War implies power, one over the other.

Balance implies union, and love, if you will allow.

The great danger that I find in modern medical practice is the apparent continued devaluation of the yin component and the overvaluation of yang; of advances in technologies, ever so fascinating and glamorous, and with impressive price tags escalating ever higher. The toys of medicine, I call them! Toys of the ever-searching scientific mind not always in touch with its yin principle, which at times loses itself in the mysteries that abound in our universe and often, carrying along the earthbound clinician, working in the real world of flesh, psyche, and disease, into that stratosphere of ideology and exquisite design.

Yes, we need a balance here and everywhere I look, it seems, in our present day world. Much of the disunity in which we abound is due very much to modern societies further devaluing yin, our mysterious mother, without whom there would be no life at all.

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1. Botticelli MG, Gilbert FI: The yin and yang of medical practice. *West J Med* 1988; 149:108-110
2. Wielheim R, Baynes CF: *The I Ching*. Princeton, NJ, Princeton University Press, 1971, pp 275-276

Recent Trends in Lung and Breast Cancer Mortality in California Women

TO THE EDITOR: We would like to bring the following information to the attention of your readers.

Cancer is the second leading cause of death in California and the United States. In 1986, the last year for which there are complete state statistics, 46,412 people died of cancer in California. That equates to 23% of all deaths or an average of 127 deaths per day.

Lung cancer has long been the leading cause of cancer death for men in California and the nation; however, it has been the leading cause of cancer death for women in California only since 1983, when it surpassed breast cancer for the first time. California was one of the first states in which lung cancer became the leading cause of cancer death in women.

In 1986, there were 4,633 deaths due to lung cancer in California women (or approximately 13 deaths per day), and 4,107 breast cancer deaths (or about 11 deaths per day).

Lung cancer deaths among California women in 1986